TCHP – CLAIM FILING DEADLINES AND PROCEDURES

These procedures and deadlines pertain to the TCHP medical, Prescription Drug Plan and Mental Health/ Substance Abuse Plan. Utilization of pharmacy and Mental Health/Substance Abuse network providers eliminates the need to file paper claims. However, if an out-of-network provider is utilized the procedures and deadlines must be followed.

Contact the appropriate plan administrator with any questions about covered services, benefit levels or claim payments.

Claim Filing Deadlines

- **All claims should be filed promptly. The Plans require that all claims be filed no later than:**

– One year from the ending date of the plan year in which the charge was incurred for claims with dates of service on or after July 1, 2001.

Claims with Service Dates of:	Final Filing Date
July 1, 2000 thru June 30, 2001	No longer eligible
July 1, 2001 thru June 30, 2002	June 30, 2003
July 1, 2002 thru June 30, 2003	June 30, 2004
July 1, 2003 thru June 30, 2004	June 30, 2005
July 1, 2004 thru June 30, 2005	June 30, 2006
July 1, 2005 thru June 30, 2006	June 30, 2007

Claim Filing Procedures

All communication to the plan administrators must include the Benefit Recipient's Social Security number (SSN) and appropriate Group Number as listed on the identification card. This information must be included on every page of correspondence.

- Complete the claim form obtained from the appropriate plan administrator.
- Attach the itemized bill from the provider of services to the claim form. The itemized bill must include name of patient, date of service, diagnosis, procedure code and the provider's name, address and telephone number.
- If the person for whom the claim is being submitted has primary coverage under another group plan or Medicare, the Explanation of Benefit (EOB) from the other plan must also be attached to the claim.
- The plan administrators may communicate directly with the plan participant or the provider of services regarding any additional information that may be needed to process a claim.
- The benefit check will be sent and made payable to the Benefit Recipient (not to any dependents), unless benefits have been assigned directly to the provider of service.
- If benefits are assigned, the benefit check is made payable to the provider of service and mailed directly to the provider. An EOB is sent to the plan participant to verify the benefit determination.
- Utilization of pharmacy network providers generally eliminates the need to file paper claims when receiving prescription drugs. When a prescription drug is purchased from a non-network pharmacy, a paper claim must be submitted to the prescription drug plan administrator for claim payment. If Medicare is primary, see Prescription Drug Plan on page 49 of this Handbook for coverage information.

Benefits for Services Received While Outside The United States

The Plans cover eligible charges incurred outside of the country for generally accepted medically necessary services usually rendered within the United States.

All plan benefits are subject to plan provisions and deductibles. The benefit for facility charges is 70% of U&C and professional charges are paid at 80% of U&C. Notification is not required outside of the United States.

Payment for the services will most likely be required at the time of services. File a claim for reimbursement with the Medical Plan Administrator. When filing a claim, enclose the itemized bill with a description of the services translated to English and the dollar amount converted to U.S. currency, along with the name of the patient, date of service, diagnosis, procedure code and the provider's name, address and telephone number.

In general, Medicare will not pay for health care obtained outside the United States and its territories. If Medicare is primary, include the Explanation of Medicare Benefits (EOMB) denying payment, along with the claim form and send to the Medical Plan Administrator.